

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Ronald Curran a prisoner at HMP Durham on 23 December 2019

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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## Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Ronald Curran, who was 83 years old, died of Motor Neurone Disease on 23 December 2019 at HMP Durham. We offer our condolences to Mr Curran's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Curran received was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation but as it was not directly related to his death, we have not included it in our report.
5. We did not find any non-clinical issues of concern. We make no recommendations.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Curran's clinical care at HMP Durham. The clinical review is attached to this report as Annex 1.
7. The PPO investigator has investigated the non-clinical issues in Mr Curran's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Curran's next of kin, a friend, to explain the investigation. He did not respond.
9. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

## Previous deaths at Durham

9. Mr Curran was the 19<sup>th</sup> prisoner to die at Durham since December 2017. Of the previous deaths, five were from natural causes, eight were self-inflicted and five were drug-related. There are no similarities between our findings in the investigation of Mr Curran's death and the other deaths.

## Key Events

10. On 15 April 2019, Mr Ronald Curran was sentenced to 15 years in prison for sexual offences. He was sent to HMP Durham.
11. On 24 April, Mr Curran went to see a prison GP. He said that he had been having trouble controlling his bowels and he had a pain in his left shoulder. Because of his age, the GP was concerned that Mr Curran might not be able to care for himself on a prison wing, so he said that he needed to be moved to the prison healthcare unit where he could be monitored.
12. On 30 May, Mr Curran was seen choking and struggling to breathe. The prison GP sent Mr Curran to hospital for further assessment. He was escorted by two prison officers. Mr Curran had a CT scan (uses X-rays and a computer to create detailed images of the inside of the body) and was returned to the prison that evening.
13. On 24 June, Mr Curran was taken to a hospital appointment. He was told that he had Motor Neurone Disease (MND). A hospital consultant neurologist discussed the diagnosis and implications with Mr Curran who understood that there was no cure and his condition could be managed only with supportive care.
14. After Mr Curran was diagnosed with MND a referral was made for palliative care, and an end of life care plan was put in place.
15. Mr Curran's health continued to deteriorate and in August prison staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Curran, who agreed that if he stopped breathing he did not want to be resuscitated.
16. On 13 December, Mr Curran was given a life expectancy of less than three months. Mr Curran said that he would like to make an application to be released on compassionate grounds. However, on 19 December, Mr Curran changed his mind and said that he would prefer to die in prison with staff who knew him.
17. On 23 December, at 11.54am, a nurse went to check on Mr Curran and saw that he was not breathing and had no pulse. Mr Curran was pronounced dead at 12.00pm.
18. The coroner accepted the cause of death provided by a prison GP and no post-mortem examination was carried out. The prison GP recorded Mr Curran's cause of death as Motor Neurone Disease.

**Louise Richards**  
**Assistant Ombudsman**

**April 2020**